Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2456AGC	A. BUILDING _____ B. WING _____	08/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIMBING ROSE CARE HOME	3848 CLIMBING ROSE ST LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted in your facility on 8/15/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility was licensed for 6 total beds. The facility had the following category of classified beds: Category 2. The facility had the following endorsements: Residential facility for the elderly or disabled persons Residential facility for persons with mental illnesses The census at the time of the survey was 5. Five resident files were reviewed and 2 employee files were reviewed. There were no complaints investigated during the survey. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2456AGC	A. BUILDING _____ B. WING _____	08/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIMBING ROSE CARE HOME	3848 CLIMBING ROSE ST LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 830 SS=D	WAIVERS 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734 , inclusive. This Regulation is not met as evidenced by: Based on interview and record review the administrator failed to submit the required paperwork requesting a waiver to care for a person receiving Hospice care for 1 of 5 residents (#5). Findings include: Resident #5 - Admission 6/1/08 The resident's file provided evidence the resident was receiving hospice care (Family Home Health Hospice) at the facility. There was no documented evidence the Administrator applied for a Hospice Waiver for this resident. BLC (Bureau of Licensure and Certification) did not receive a hospice waiver packet for the resident. Interview	Y 830		

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2456AGC	A. BUILDING _____ B. WING _____	08/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIMBING ROSE CARE HOME	3848 CLIMBING ROSE ST LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 830	Continued From page 2 The caregiver confirmed the resident was receiving hospice care services. Severity 2 Scope 1	Y 830		